CURRENTLY

Two Child Fatality Review Processes

Colorado Department of Human Services reviews

Deaths of children who have touched the system within the last two years

Local DHS reviews within sixty (60) days

State Child Fatality Review team review within thirty (30) days

Published on website and put in annual report within 187 days

Colorado Department of Public Health and Environment reviews

All child deaths

Local review in Judicial District (only 4 Judicial District have established local review teams), subject to appropriations

> State Child Fatality Prevention Team review CDPHE

Most recent annual report that is posted on the website is from 2007 (due to lack of resources)

PROPOSED

According to SB 13-255

Colorado Department of Human Services reviews

Child Deaths within three (3) years

Local DHS reviews within sixty (60) days

State CFR team review within fifty-five (55) days

Published on website and put in annual report within 212 days

Colorado Department of Public Health and Environment reviews

All child deaths

Local public health agencies convene reviews and enter data into state system

State Child Fatality Prevention Team review on or before July 1st

Publish report on or before July 1st



The departments will collaborate to make joint recommendations to the General Assembly and the Governor.

These recommendations will be made publicly available.



PLEASE SUPPORT SB13-255

CONCERNING CHILD FATALITY REVIEW TEAMS AND PROCESSES

Sens. Kefalas & Newell/Reps. May & Singer

WHY THIS BILL IS IMPORTANT FOR PREVENTING CHILD FATALITIES

- Helps prevent child fatalities through policy recommendations based on strengths and weaknesses found in systemic evaluations of child fatalities across the state
- Local review teams are evidence-based and considered best-practice for the prevention of child fatalities
- Closes the gap of unreviewed child fatalities ensuring that every child fatality gets a case-specific review

WHAT THIS BILL DOES

Colorado Department of Public Health and Environment (25-20.5-4..)

- Ensures that local/regional child fatality prevention review teams conduct case specific reviews for every child fatality of children under the age of 18 related to the following causes:
 - Undetermined causes
 - o Unintentional injury
 - o Violence
 - Motor vehicle incidents

- o Child abuse or neglect
- Sudden unexpected infant death or
- Suicide
- Organizes local/regional teams through local public health organizations
- · Local/regional teams will report findings to agencies that have responsibilities for children
- Local/regional teams will report findings to the state database system
- State team ensures evaluation of systemic trends of child fatalities based on local data
- State team ensures recommendations to the Governor and Legislature regarding child fatality prevention
- State team will provide training, technical assistance, and support to local review teams

Colorado Department of Human Services (26-1-139)

- Ensures ALL child fatalities with previous involvement with any county department of human services under the purview of CDHS, within the past 3 years gets reviewed
- Expands the timeline to complete the final child fatality review report by 25 days
- Public disclosure includes recognition of race, gender, age, and ethnicity in compliance with federal Child Abuse
 Prevention and Treatment Act
- Ensures collaboration with CDPHE to provide recommendations about egregious child abuse and neglect, near child fatalities, and child fatalities

BACKGROUND

- Since 2007, 202 children have died of abuse and neglect in CO and 75 of those children had parents or caregivers who were known to the child welfare system
- Since 2003, the rate of child fatalities caused by abuse or neglect, with previous department involvement has risen from 29% to 35%
- In 2011, 49% of child abuse and neglect fatalities were Latino children and 80% of the fatalities were children under the age of 5yrs
- In 2011, the child abuse and neglect rate was 8.3 per 1000 children
- In 2011, there were 14.9 child deaths per 100,000 children (ages 1-14); in the same year, there were 45.2 deaths per 100,000 in children (ages 15-19)

Supporting Organizations Include

American Academy of Pediatrics, CO Chapter Children's Hospital Colorado Colorado Association of Family and Children's Agencies Court Appointed Special Advocates (CASA) Every Child Matters National Association of Social Workers, CO Chapter Office of the Child's Representative Office of Colorado's Child Protection Ombudsman Tennyson Center for Children